ST. ALOYSIUS MEDICAL HISTORY EVALUATION

PART I: INFORMATION *(To be filled out by parent or guardian only)*

Name:____Sex: M F Date of Birth: ________________________________ Grade: ____________

Parent or Guardian:____

PART II: MEDICAL HISTORY *(To be filled out by parent or guardian)*

Has or Does this athlete **Circle & please explain all "yes" answers below**

1. Have a medical problem or injury since his/her last evaluation? .... YES NO
   Ever not been allowed to participate in sports for a medical reason?........ YES NO
2. Ever been hospitalized? .... YES NO
   Ever had surgery? .... YES NO
   Have any missing organs? *(eye, kidney, testicle, etc.)* .... YES NO
3. Presently take any medication? .... YES NO
4. Have any allergies to medicine or insect bites? .... YES NO
5. Passed out during or after exercise? .... YES NO
   Been dizzy or passed out during or after exercise?........ YES NO
   Have chest pain during or after exercise? .... YES NO
   Tire more quickly than his/her friends during exercise?........ YES NO
   Have high blood pressure? .... YES NO
   Been told he/she has a heart murmur?........ YES NO
   Have racing of the heart or skipped heartbeats? .... YES NO
   Have a family member that died of heart problems or sudden death before age 50?........ YES NO
6. Have any skin problems?........ YES NO
7. Ever had a head or neck injury? .... YES NO
   Ever been knocked out or unconscious? .... YES NO
   Ever had a seizure?........ YES NO
   Ever had a stinger, burner or pinched nerve?........ YES NO
8. Ever had heat cramps?........ YES NO
   Ever been dizzy or passed out in the heat?........ YES NO
9. Have trouble with breathing or coughing during or after activity? .... YES NO
10. Use any special equipment? *(pads, braces, neck rolls, eye guards, kidney belt, etc.)* .... YES NO
11. Have any problems with vision? .... YES NO
    Wear glasses or contacts?........ YES NO
12. Ever sprained/strained, dislocated, fractured or had repeated swelling of any bones or joints?........ YES NO

13, Have any medical problems listed below? *(Please check off)*

_______High Blood Pressure _______Rheumatic Fever _______Diabetes _______Hepatitis

_______Mononucleosis _______Abnormal Bleeding _______Tuberculosis _______Asthma

_______Sickle Cell Disease/Trait _______Other*(list)* ____

14. List dates for last: Tetanus Shot:____________________________Measles Immunization:________________________________
15. Female athletes, list dates for: First menstrual period:______________________Last menstrual period:______________________

Longest time between periods last year:____

Please explain all "yes" answers from above:____

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____

PART III: SIGNATURES

(You must answer these questions and sign for your child to be examined)

1. The information on the reverse is current and correct to the best of my knowledge .... YES NO
2. I give my permission for my child to be examined for school-related activities .... YES NO
3. If, in the judgment of a school representative, the named student athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary............ YES NO
4. I recognize the evaluation to be done on my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac testing will be performed .... YES NO
5. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately .... YES NO
6. I give my permission for the coach/athletic director to release information concerning my child's injuries to the coach/athletic director/principal of his/her school. .... YES NO

Signature of Parent/Guardian:________________________________ Date:________________

PART IV: PHYSICAL *(To be filled out by a licensed physician /licensed nurse practitioner in collaboration with doctor or a licensed physician's assistant under the supervision of a licensed physician.)*

		Height	**Weight**		**Blood Pressure /**	**Pulse**
COMPLETE	LIMITED	SYSTEM	NORMAL	ABNORMAL	INITIALS	COMMENTS
		Heart				
		Lung				
		Other				
		Abdominal				
		Genitalia				
		Neck				
		Shoulder				
		Elbow				
		Wrist				
		Hand				
		Back				
		Knee				
		Ankle				
		Foot				
		Eye	Right 20/	Left 20/	Corrected?	YES / NO

CLEARANCE: _________A. Cleared

_________B. Cleared after further evaluation/treatment

_________C. Not cleared for: _________Collision _________Contact _________Non-contact

RECOMMENDATIONS:________________________________

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NAME OF MD/NURSE PRACTITIONER:________________ **DATE:**________________

ADDRESS:________________ **TELEPHONE:**________________

SIGNATURE OF MD/NURSE PRACTITIONER:________________________________